PROVIDER RECIPIENT ASSIGNMENT REQUEST

I. PROVIDER – RECIPIENT ASSIGNMENT REQUEST

Provider Name										
Provider Medicaid NPI Number										
Date: MM/DD/YY										

Please assign the following recipients to the above provider's panel:

RECIPIENT NAME	RECIPIENT MEDICAID ID NUMBER	DATE OF BIRTH
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Authorized Signature:

_____

II. Fax to: Managed Care Helpline 1-800-613-5955